Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration

Electronic Billing

April 2000

About this publication

This publication supersedes all previous MAA Electronic Billing Manuals and Medical News Bulletin 9/93 #1, Issued September 27, 1993.

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Important Contacts

A provider may use MAA's toll-free lines for questions regarding its programs, however MAA's response is based solely on the information provided to the [MAA] representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern MAA's programs.

Where do I call for information on becoming a DSHS provider?

Provider Relations Unit
(800) 562-6188 **-or-**

Provider Enrollment Unit
(360) 725-1033, (360) 725-1026,
(360) 725-1032

Whom do I call for authorizations?

Acute Physical Medicine & Rehabilitation	**1-800-634-1398**
Durable Medical Equipment & Prosthetics & Orthotics	**1-800-292-8064**
Hospice	**1-800-545-5392**
Pharmaceutical/Drugs	**1-800-848-2842**
Out-of-State Commercial Air Transportation	**1-360-725-1552**

Note: Hospice requires provider notification within 5 days of client admit. Providers should fax the 5-day notification (see Hospice Billing Instructions) to: (360) 586-5299 or call (800) 545-5392

Where do I get copies of billing instructions?

Check out our web site
http://maa.dshs.wa.gov **or-**
Provider Relations Unit
PO Box 45562
Olympia, WA 98504-5562
1-800-562-6188

Whom do I contact if I have questions on…

Billing procedures, payments, denials, or Explanation of Benefits (EOB) on Remittance and Status Report (RA)?

Provider Relations Unit
1-800-562-6188

Home Health Program Medical Review
1-360-725-1582

Private insurance or third party liability, other than Healthy Options?

Division of Client Support
Coordination of Benefits Section
PO Box 45565
Olympia, WA 98504-5565
1-800-562-6136

Computer program problems (e.g., which fields to use, where to key information, the different screens available for use)**?**
Call your software company or
OIS at (360) 725-1267

Locating claims on the RA that your records show being submitted to MAA through the billing company or intermediary?
Call your intermediary or billing company.

Technical questions regarding transmission or if you are having problems and need to verify if your file has been received?

Electronic Billing Unit
1-360-725-1267

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Definitions

The section defines terms and acronyms used in these billing instructions.

Authorization - Official approval for department action.

Authorization Number - A nine-digit number that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pended, or denied.

Authorization Requirement - In order to obtain authorization for some services and equipment, you must provide proof of medical necessity. Each request must include a complete, detailed description of the diagnosis and/or any client-specific disabling conditions, justifying the need for the equipment or the level of service being requested.

Balancing and Verification – The procedure used to edit the data contained in the file/submission to be certain that all the data is captured.

Benefit Period - Means the time period used in determining whether Medicare can pay for covered Part A services. A benefit period begins the first day a beneficiary is furnished inpatient hospital or extended care services by a qualified provider. The benefit period ends when the beneficiary has not been an inpatient of a hospital or other facility primarily providing skilled nursing or rehabilitation services for sixty consecutive days. There is no limit to the number of benefit periods a beneficiary may receive. Benefit period also means a `spell of illness' for Medicare payments.

Carrier - A private organization (usually an insurance company) that has a contract with the federal government to 1) review, approve and/or deny claims, and 2) process the paperwork for Medicare Part B (medical insurance). For Medicare Part A, these companies are called *intermediaries*.

Claims – Medical bills or invoices for services provided to Medicaid clients.

Client - An applicant for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Coinsurance - The portion of reimbursable hospital and medical expenses, after subtraction of any deductible, which Medicare does not pay. Under Part A, coinsurance is a per day dollar amount. Under Part B, coinsurance is twenty percent of reasonable charges.

Community Services Office (CSO) - An office of the department that administers social and health services at the community level. (WAC 388-500-0005)

Core Provider Agreement - A basic contract that the Medical Assistance Administration (MAA) holds with medical providers serving MAA clients. The provider agreement outlines and defines terms of participation in the Medicaid program.

Deductible - An initial specified amount that is the responsibility of the client.

(a) Part A of Medicare - inpatient hospital deductible' means an initial amount of the medical care cost in each benefit period which Medicare does not pay.
(b) Part B of Medicare - physician deductible' means an initial amount of Medicare Part B covered expenses in each calendar year which Medicare does not pay.
(WAC 388-500-0005)

Department - The state Department of Social and Health Services.
(WAC 388-500-0005)

Disk Operating System (DOS) – An operating system for computers that use disk and diskettes for auxiliary storage for programs and data.

Electronic Media Claims – Submission of claim via the following media:

- Mainframe to mainframe;
- Magnetic tape;
- Personal computer via either a public communications network, CROSSTALK, 3780 BI-SYNC; or
- Floppy disk.

Expedited Prior Authorization (EPA) - The process of authorizing selected services in which providers use a set of numeric codes to indicate to MAA which acceptable indications, conditions, diagnoses, and/or criteria are applicable to a particular request for services.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers that display transaction information regarding Medicare claims processing and payments.

Intermediary – A third party employed by the Medicaid provider to submit claims to the Division of Program Support.

Julian Date – Consecutively numbered day of the year (e.g., January 1 is 001, January 31 is 031, February 1 is 032, etc.).

Local Area Network (LAN) – Medical Assistance claims network.

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. (WAC 388-538-050)

Maximum Allowable - The maximum dollar amount that a provider may be reimbursed by MAA for specific services, supplies, or equipment.

Medicaid - The state and federal funded aid program that covers the Categorically Needy (CN) and Medically Needy (MN) programs.

Medicaid Management Information System (MMIS) – The systems, structures, and program that MAA uses to process medical invoices.

Medical Assistance Administration (MAA) - The administration within the Department of Social and Health Services authorized by the secretary to administer the acute care portion of the Title XIX Medicaid and the state-funded medical care programs, with the exception of the certain non-medical services for persons with chronic disabilities.

Medical Assistance IDentification (MAID) card – MAID cards are the forms DSHS uses to identify clients of medical programs. MAID cards are good only for the dates printed on them. Clients will receive a MAID card in the mail each month they are eligible.

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. (WAC 388-500-0005)

Office of Information Services (OIS) – The section within the Medical Assistance Administration which processes electronic claims.

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each Medicaid client and which consists of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Personal Computer (PC) – A desktop, floor standing, or portable microcomputer that usually consists of a system unit, a display monitor, a keyboard, one or more diskette drives and or internal fixed drive.

Prior Authorization - Approval, based on medical necessity, required from the Medical Assistance Administration for certain services, items, or supplies.

Program Support, Division of (DPS) - The division within the Medical Assistance Administration which processes claims for payment under the Title XIX (federal) program and state-funded programs.

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement [Core Provider Agreement] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. (WAC 388-500-0005)

Random Access Memory (RAM) – A storage device that organizes and controls data in a way that enables the data to be stored and retrieved directly to specific locations.

Remittance And Status Report (RA) - A report produced by the MMIS system that provides detailed information concerning paid, returned, pending, denied and adjusted claims. This report is produced once each week for each provider who has Medicaid claims activity.

Revised Code of Washington (RCW) - Washington State laws.

Submitter – A provider or intermediary submitting claims to Division of Program Support/Office of Information Services.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. (WAC 388-500-0005)

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.
(WAC 388-500-0005)

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

Electronic Billing

The State of Washington is among the leaders in electronic billing. Currently, 85% of all claims received by the Medical Assistance Administration's (MAA), Office of Information Services (OIS) are submitted electronically by various methods.

Providers throughout the state have taken advantage of electronic capabilities to expedite claims submissions and avoid delays associated with processing paper claims. Currently, over 10,000 medical providers experience the benefits of electronic billing.

We think you will find the switch from paper claims submission to electronic claims submission very beneficial.

Benefits of Electronic Billing

- Faster Cash Flow;
- Faster Claim Submission;
- Reduced Handling and Postage Costs;
- Reduced Claim Turnaround Time;
- Better Management of Billing; and
- Capability to Purchase Commercially Available Billing Packages.

The most difficult task associated with Electronic Billing is conducting an analysis to determine which option is right for you. Although MAA cannot recommend a particular option, we are glad to assist you in identifying questions you have before making your decision.

The Electronic Billing option may not solve all billing problems you may be experiencing. MAA encourages providers to call the Provider Relations Unit at 1-800-562-6188 to resolve billing problems **prior** to beginning electronic billing. Provider Relations can arrange for on-site training to analyze and correct billing practices, so they do not interfere with the speedy processing of electronic claims.

Hours of Operation

The Local Area Network (LAN), for submitting electronic claims via personal computer, is available 24 hours a day, 7 days a week. OIS may need to bring the system down for maintenance or repair; however, this is kept to a minimum. The system is down for approximately 15-20 minutes each day to download files for the daily edit process.

Getting Started

What are the ways I can submit claims electronically?

MAA's Office of Information Services (OIS) has made it possible for providers to submit claims electronically in several different ways. The following is a list of those ways, along with the specifications for each:

1. **CROSSTALK**

   A telecommunications software package available in most computer stores.

   Hardware and software minimum requirements:

   - IBM or IBM compatible PC with communications capability;
   - 256K RAM;
   - MS or PC Disk Operating System (DOS);
   - 3-1/2" disk drive;
   - Dial up dedicated phone line (not an inter-office switching system);
   - 1200, 2400, 9600, 28.8 or 56K baud modem;
   - CROSSTALK XVI or compatible software package; and
   - Software to enter and format medical claims per OIS personal computer specifications.

2. **3780 BISYNCHRONOUS COMMUNICATIONS**

   OIS has installed a 3780 BI-SYNC (BSC) emulation board in an IBM compatible personal computer to accommodate providers wishing to communicate using a 3780 bisynchronous protocol.

   Hardware and software requirements:

   - Computer with 3780 BI-SYNC (BSC) protocol capability;
   - Dial up dedicated phone line (not an inter-office switching system);
   - Bell 201 (2400 baud) or Bell 208 (4800 baud) modem; and
   - Software to enter and format medical claims per OIS personal computer specifications.

3. **FLOPPY DISKS**

This option allows providers to mail their floppy disks containing claims data to OIS. OIS personnel will extract the disk contents for processing and return the disk to the provider.

Hardware and software requirements:

- 3-1/2" disk;
- Disk must be formatted with MS or PC Disk Operating System (DOS);
- Software to enter and format medical claims per OIS personal computer specifications; and

4. **MAINFRAME TO MAINFRAME**

This option allows providers or intermediaries with mainframe computer systems to communicate and transmit data to the MMIS.

Hardware requirements:

- 3780 BI-SYNC Protocol;
- Dial up dedicated phone line (not an inter-office switching system);
- Bell 208 modem (4800 or 9600 baud); and
- Software to enter and format claims per OIS mainframe specifications.

5. **MAGNETIC TAPE**

Providers have the option to submit their claims to OIS on magnetic tape. OIS also has the capability to produce your Remittance and Status Report (commonly referred to as Remittance Advice or RA) on a magnetic tape*.

Hardware and software requirements:

- 9-track tape drive/tape;
- Formatted for 1600 or 6250 BPI; and
- Software to enter and format medical claims per OIS magnetic tape specifications.

* Call (360) 725-1267 if you wish to have OIS produce RAs by magnetic tape.

What forms must I fill out prior to billing claims electronically?

Before submitting claims electronically, you must fill out the following Electronic Media Claim (EMC) agreements for each "pay-to" or billing provider number. Blank agreements are available from the Division of Program Support (DPS) by calling 1-800-562-6188.

- **Electronic Billing Agreement** – Completed by all providers who wish to submit electronic claims information. This document details the responsibilities of the Medicaid provider.

- **Request For Submitter Identification Number** - Completed by the electronic claim submitting entity.

- **Disclosure Statement** – Completed by providers or intermediaries who use the Direct Entry billing option.

- **Power of Attorney** – Completed by providers who use an outside firm/intermediary to submit their electronic claims information.

  The Power of Attorney document transfers the signature rights to the data processing firm to certify that the data submitted meets the requirements of the Federal Fraud and Abuse Act. The Power of Attorney must be notarized.

  Note: In accordance with **42 CFR 447.10(f)**, payment made to the intermediary by the provider must be based upon the cost of processing the provider's claims, and may not be related to a percentage or other basis to the amount billed or collected. Payment to the intermediary may not be dependent upon payment by the State for the provider's claims.

Where do I send the completed forms?

Return all completed forms/agreements to:

Division of Program Support
Provider Enrollment Unit
PO Box 45562
Olympia, WA 98504-5562

File Format

Overview

Computers require information to be received in a standard format. In this way, the computer's "brain" knows what to expect and can tell if all information transmitted is received.

This is especially important in electronic billing and is the reason for the following file specifications. This standard arrangement of data is called a "file format." In the file format, each piece of information has its assigned space that may not vary from claim to claim or from file to file. Although a printed file format may look to the casual observer like "alphabet soup," with a little practice it is easy for anyone to tell whether a file is in the correct format.

How to Arrange Your Data

The following technical specifications are divided into "records." Each record provides the computer with a different type of information. The following short descriptions are provided to help visualize how the information is arranged.

Record 1: Transmitter Header Control Record - The data it contains tells the computer who the submitter is and what the transmission will look like.

Record 2: Submitter Header Record - Tells the computer your submitter ID number, the type of claims you are sending, and the date file was created.

Record 3: Claim Header Record - Provides "header" information about the specific claim such as patient identification code (PIC), your billing provider number, total dollars billed for this claim, and so on. Much of this data is information you also provide on paper.

Record 4: Claim Detail Record - Contains the detail information of the claim such as dates of service, individual procedure codes, and tooth numbers for dental claims.

Record 5: Submitter Trailer Record - Tells the computer that you are finished sending this file. It contains file count and dollar amount balancing information to be sure that all data was captured correctly.

Record 6: Transmitter Ender Control Record - It repeats information from the transmitter header control record so that the file can be balanced with that record.

In Addition:

- The electronic billing record is 80 characters in length.
- The first 8 characters are used for data control, and the remaining characters are the first or second part of the split electronic billing record.
- To make up these first 8 characters, 4 new fields are inserted at the beginning of the record definitions.
- The personal computer billing logical record (the standard arrangement of information mentioned earlier) is split into two physical 72-character records.
- The record delimiter is the carriage return/line feed (CR/LF) included in the 80th character.

Balancing and Editing Data

Make sure to balance and edit data

The purpose of these procedures is to balance and edit the data contained in the submission and to be certain that all data is captured. Office of Information Services (OIS) will perform the following verification and balancing procedures:

Transmitter Header Control Record

- The first record present on the file is the record of a transmitter header-transmitter ender control group.
- Submitter ID number is active and valid.
- Sequence number begins with one and is incremented by one for each consecutive control group, and matches the sequence number in the transmitter ender control record.
- Fields are properly formatted.

Header and Detail Claim Records

- Submitter ID number is identical to that on submitter header record.
- Claim record ID is valid for the type of claim contained in the file. (Example: if submitter header record ID is "A1," claim header ID must be "HM," and submitter trailer ID must be "Z9.")
- Claim sequence number corresponds to the fact that the record is the first (or subsequent) record for the claim. Depending on the claim type, there can be more than one physical record per claim.
- Fields are properly formatted.

Transmitter Ender Control Record

- Submitter ID matches the submitter ID in the transmitter header control record.
- Record count equals the number of logical records within the transmitter header – transmitter ender control group. (This count does not include the transmitter header or the transmitter ender control record.)
- Sequence number matches the sequence number in the transmitter header control record.
- Fields are properly formatted.

We recommend that submitters build these edits into their systems.
This will help ensure efficient processing.

Initiating/Testing Electronic Billing

Verification of Electronic Media Claim Agreements

The Division of Program Support (DPS) will process the Electronic Medical Claim (EMC) agreements within 10 days of receipt and send confirmation of acceptance for the EMC program to the provider and the intermediary.

DPS will assign a "submitter ID number" to the submitter of electronic claims to enable system activation of the test data.

Test Submissions

The submitter will then send a test submission(s) that contains either "live" or "dummy" test data.

- Submissions must conform to the technical specifications of this billing manual and must contain at least 5, but not more than 15, claims.
- The submissions must be identified "file named" using the submitter ID number assigned with a Julian date extension. (EXAMPLE: 8012345.162)
- OIS will process submissions as soon as possible after receipt and will inform the submitter of the test results in a timely manner.

To track test submissions more efficiently, submitters must call OIS at (360) 725-1267 to alert the EMC coordinator before any test. (Be sure to leave a contact person, telephone number where you can be reached to give the results of the test submission, and file name.)

Once your test submission has been approved and you begin billing live data, no ongoing checks or verbal verification of receipt of your file will be available. The weekly Remittance and Status Report (RA) will contain the status of all claims received into the MMIS.

Remittance and Status Report

A paper or magnetic tape Remittance and Status Report (RA) is generated weekly for each provider who has claims in the MMIS. The RA identifies claims received and supplies information concerning payment, denial, return, and processing status of pending claims. **If you don't see your claim on your RA after 30 days from an electronic submission, please call OIS at (360) 725-1267.** The RA is a good indicator of any processing or billing problems associated with electronic billing. Magnetic tape Remittance Advice specifications may be requested by calling OIS at (360) 725-1267.

How long should I keep my files?

- It is necessary to maintain files **for at least two (2) weeks after transmission**, so they can be retransmitted if errors are detected in the original submission.

- If transmission errors occur, the submitter will be informed promptly.

How long do I keep my source documents and supporting data?

Requirements for retention of source documents are specified in the "Electronic Billing Agreement." All regulations and requirements regarding audit trails and supporting data retention are applied equally to electronic and paper claims.

How Electronic Claims Are Processed

Step 1 – Initial Edits/Assigning Claim Number

- As files are read into the computer, the preprocessor program performs the edits explained in the section Balancing and Editing Data.

- A microfilm copy of each claim record is produced by the MMIS (Medicaid Management Information System) and is filed with the Office of Information Services (OIS).

Step 2 – Main Payment System

- The claims are next fed into the MMIS where they undergo all the edits and audits that apply to paper claims.

- The computer assigns a unique ICN (Internal Control Number/Claim Number) onto each claim record. The ICN is reported to the provider on either a paper or tape remittance advice as the "claim number."

- Claims passing all edits and audits ("clean claims") will enter the payment queue and be processed during the next payment cycle.

- Claims that suspend are manually reviewed by the Division of Program Support (DPS).

- Denied claims appear on the Remittance Advice (RA) with an Explanation of Benefits Code (EOB) explaining the reason for the denial.

Note: **Claims must be received by noon on Tuesday in order to be processed in that week's payment cycle. (Holidays may alter this schedule. Please see your recent RA for changes to the normal payment cycle.)**

Claims Requiring Comments or Backup Documentation

Most claims can be billed electronically regardless of whether backup documentation or special comments are necessary to explain unusual circumstances. This section will explain when and how to use either the "Detail Narrative Comments" field (known as the *Remarks/Comments* field) on the EMC record and the "Batch Header for Backup Documentation" form.

When are comments or documentation required?

MAA suggests that providers familiarize themselves with the appropriate MAA billing instructions and numbered memoranda to know when billings will require *Comments* or backup documentation.

> **Many times documentation or *Comments* are submitted when there is no requirement to do so. Unnecessary documentation/ comments slows down processing!**

If you are in doubt about whether to send backup documentation or enter *Comments*, please call the Division of Program Support toll-free at 1-800-562-6188.

Examples of electronic claims that may require backup documentation or comments are:

- Third Party Liability (Insurance) claims-injury reports, Explanation of Benefits (EOB) from insurance companies, Medicare, etc.
- Claims where Medicaid eligibility is newly established or in question.
- Claims for procedures that are listed in MAA's fee schedule as "By Report" under the Maximum Allowable column.
- Claims which require special handling.
- Claims for home health providers during agency designated review period. Home Health documentation must be mailed prior to submitting electronic claim if on Focused Medical Review. Mail justification to: Home Health Nursing Care Advisor, PO Box 45506, Olympia, WA 98504-5506.
- Claims for both miscellaneous oxygen-related durable medical equipment and repairs and non-routine service on medical oxygen equipment.

Using the *Remarks/Comments* Field

The medical payment system will suspend any claim with data in the *Remarks/Comments* field so that a claims examiner can process it manually based on the content of the comments. Whenever possible, use the *Remarks/Comments* field instead of submitting paper backup documentation. This will allow for faster processing of the claims.

- You can enter up to 40 characters per detail line in the *Remarks/Comments* field.
- Any information entered in this field will cause the claim to suspend in MMIS for manual processing.
- Comments must be in all capital letters to ensure that the message is correctly received.
- Comments that apply to the entire claim DO NOT have to be repeated on each detail line. The comments may appear on the first detail line and will be applied to the entire claim. Each successive detail line may be used to supply additional information.
- Make sure remarks are essential to the processing of the claim so it is not suspended unnecessarily.

Do not submit comments such as routine procedure or diagnosis code descriptions, as they will cause needless delay in payment.

Appropriate Comments

Appropriate comments may include, but are not limited to, the following:

- ✓ "Ventilator patient-Key "0" in ITA field"
- ✓ "End date of service – 05/04/00"*
- ✓ "Rebilling – ICN 30012588015000092"**
- ✓ "Fell at home – no insurance involvement"
- ✓ "NEMB" (not eligible for Medicare benefits)
- ✓ Whether the patient being seen is "Twin A," "Twin B," etc.
- ✓ Name and strength of chemotherapy drugs (i.e. Adriamycin 50 mg.)

***Note:** This allows billing of consecutive services (such as consecutive hospital calls) on one line of service. DPS will enter the ending date of services in the claim record. Be sure to enter the correct number of days or units when using this feature.

****Note**: Use the ICN of the first claim submitted to establish timeliness of any rebilling of the same claim.

Span of Service Dates for Noninstitution Claims
If your billing instructions allow your services to be billed as a consecutive span of dates (e.g., hospital calls), enter the "FROM" date in the date of service field and the "TO" date in the ***Remarks/Comments*** field. (If you use the Multi-Insurer format, put the "TO" date in the "TO DATE OF SERVICE" field.) The units/quantity must reflect the total number of days you are billing.

Other Appropriate Comments

- **Insurance Involvement**

  - ✓ The *Remarks/Comments* field may be used in place of the "Injury Report" form when there is possible insurance involvement. Since each detail line of the claim may contain up to 40 characters of comments, it is possible to supply all necessary insurance data by using consecutive details.

  - ✓ Some or all of the following information is helpful and will allow DPS to process your claim quickly and accurately. If you have questions concerning third party liability information, call toll free 1-800-562-6136.

- **Casualty Cases**

  - ✓ How, where, and when injury occurred – e.g.: "fell at home 5/25/00," "MVA – 5/25/00" (motor vehicle accident).

  - ✓ Names and phone numbers of insured, attorney, and insurance company, and those involved in the accident.

- **For Health Insurance Cases:**

  - ✓ Name, address, and telephone number of insurance company.

  - ✓ Name and telephone number of insured/subscriber.

  - ✓ Social security number of insured.

  - ✓ Name and telephone number of employer.

  - ✓ Policy or group number.

EPSDT/Healthy Kids Claims

EPSDT claims may be processed without using the ***Remarks/Comments*** field. The screening indicators (YR, NR) must be keyed in the modifier field. **NOTE: If you are billing for other services, such as lab or immunizations, and you are not billing for a screening, do not enter the screening indicator - LEAVE IT BLANK.**

Treatment of a problem found during screening must be billed on a separate claim without the indicator.

Backup Documentation

If the *Remarks/Comments* field does not allow you enough space to provide information to process the claim, you may need to send hard copy documentation to support the billing. Information that cannot be transmitted electronically, but is necessary to correctly process an electronic claim, is considered backup documentation.

Examples of backup documentation are: Medical Assistance IDentification (MAID) cards, Remittance and Status Reports, consent forms, insurance denials, operative reports, home health plan of treatment, and dental charts.

- If documentation must be submitted separately, one of the indicators listed below in the first position of the *Remarks/Comments* field. This indicator will cause the claim to suspend and will indicate to the claims examiner that documentation has been submitted separately.

- The following indicators have been assigned for this purpose:

  "X" Every claim submitted with **non-insurance related** backup documentation must have an "X" in the first position of the *Remarks/Comments* field.

  "I" Every claim submitted with **insurance related** backup documentation must have an "I" in the first position of the *Remarks/Comments* field.

If you have both types of backup, use both the "X" and the "I" in the first and second position of this field.

For casualty/accident claims, send applicable accident or injury report. Include how injury occurred, name, address, and telephone of attorney, insurance company, and insured, and where the injury occurred.

For health insurance claims, send insurance company EOBs showing unmet deductibles, noncovered charges, noncovered dates, coverage termination dates, noncovered patients, and insurance payments showing that insurance paid less than the DSHS maximum allowable amount.

The "X" and "I" identifiers are the ONLY way to alert the claims processing staff to match the claim with the backup documentation.

ITA Claims

Claims for clients under the Involuntary Treatment Act (ITA) must have the appropriate program forms submitted as backup documentation (e.g., DSHS 13-628: Client Information Involuntary Treatment Act, DSHS 14-01: Request for Assistance). Enter an "X" in the ***Remarks/Comments*** field to indicate backup is being sent. Also enter the letters "ITA" in the ***Remarks/Comments*** field.

Submit backup in the following manner:

Immediately after the transmission or magnetic tape has been sent, follow the procedures below to submit backup documentation:

- Documents smaller than the standard 8-1/2" x 11" size (e.g., MAID cards, invoices, Remittance Advices) must be copied to 8-1/2" x 11" sheets of paper so the documents are not lost and can be easily scanned. The copies must be clean (no shaded areas).

- Please do not use staples, labels, scotch tape , or highlighting on your backup documents. These make it difficult to scan these documents and any highlighting results in shading the highlighted area completely out.

- The sheets must be attached to a Batch Header sheet and a Client Listing. See page 22 for a sample copy. Please make copies of these forms, as necessary. You must submit only one Batch Header and one Client Listing per claim type.

  - ✓ Organize all backup documentation in alphabetical order by client's last name.
  - ✓ Place a Backup Detail Sheet (pg 23) in front of each client's documentation.
  - ✓ List each client's name in alphabetical order on the Client Listing form.

- The intermediary or provider must complete the attached Batch Header sheet or computerized facsimile and Client Listing indicating patient names in alphabetical order. This will identify which claims in the transmission have an "X" or "I" in the *Remarks/Comments* field.

DPS will hold suspended claims awaiting receipt of backup documentation for 15 working days. If backup documentation is not received within that time, DPS will deny the claim(s) in question. DPS will notify the provider via the Remittance and Status Report (RA) with a message stating "Backup documentation required for processing was not received."

All claims that suspend for backup documentation or comments will require manual processing which takes additional time.

NOTE: Home health backup documentation is not microfilmed. Mail home health backup documentation directly to:

Quality Fee-for-Service
Home Health Nursing Care Advisor
PO Box 45506
Olympia, WA 98504-5506

Completing the Batch Header

(Circled numbers correspond to those on the attached example)

① You must indicate what **method** you use to submit your claims (e.g., Mainframe, PC to DSHS, or Magnetic Tape).

② List the **facility name** or **provider name** from which backup is being sent.

③ Enter the **billing provider number.**

④ Enter the **file name** of the EMC file that was transmitted.

⑤ If you are submitting more than one file per batch, please indicate the **file number** to which the documentation belongs (file 1, 2, 3, etc.).

Enter the **submitter I.D.** This is the seven-digit number assigned to you for submission purposes.

⑦ Indicate the exact **transmission date.** If you are not sure, do not guess or your documentation could be matched to the **incorrect batch**. If a billing service submitted the EMC batch for you, get the exact date from them.

⑧ Enter one of the **claim types** below:

PHYSICIAN	**J**	**DENTAL**	**K**
EPSDT	**L**	**INPATIENT**	**S**
MEDICAL VENDOR	**P**	**DRG**	**R**
PHARMACY	**D**	**OUTPATIENT**	**M**

⑨ Indicate how many **claims are in the file** you submitted. This also helps match your backup to the claims.

Remember to submit a separate Batch Header sheet for each different batch. Each file is issued a separate claim number series, therefore it must be submitted with its own Batch Header sheet to ensure proper matching of the electronic claim to the backup documentation.

Backup documentation must be received by the Division of Program Support (DPS) within 10 working days of the transmission of the file or tape.

Send your backup to: **DIVISION OF PROGRAM SUPPORT**
ATTN: CLAIMS CONTROL UNIT
PO BOX 45560
OLYMPIA WA 98504-5560

Batch Header Backup Documentation Form

Client Listing

Client Listing

Detail Backup Sheet

Rebillings and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems you may experience. Knowing when to use the rebilling process versus the adjustment process is important and may save you frustration.

Rebillings

Rebill when:

- **The claim is denied in full due to an error in billing**. When the entire claim is denied, make the appropriate corrections and resubmit your claim.

- **An individual line is denied on a multiple-line claim due to an error in billing**. The denied service by itself may be submitted as a rebill, unless the claim contains multiple surgical procedure codes. (See Adjustment section.)

- **The claim does not appear anywhere on your Remittance and Status Report.** If 90 or more days have elapsed since you sent your electronic claim to MAA, and it has not appeared on your Remittance and Status Report, contact your intermediary or billing company.

When submitting a rebilling that is beyond the 365-day billing time limit, reference the original Internal Control Number (ICN) that reflects the specific denial. This original ICN number verifies that your claim was originally submitted *within* the time limit. (*Note*: if rebilling electronically, the ICN should be indicated in the R*emarks/Comments* field.)

In order to be reimbursed for services, you must submit your claims to MAA within 365 days from the date of service. (Refer to WAC 388-502-0150.)

Adjustments

Adjustments **CANNOT** be billed electronically.

How to submit adjustments

- All **adjustments** must be submitted on the **blue Adjustment Request** 525-109 form.
- Use only one adjustment request form per claim.
- Submit multiple line corrections to a single claim on one adjustment request form.

Rebillings are not appropriate for the following situations. You must submit an adjustment when:

- **The claim was paid.** Line items or claims paid at an amount less than MAA's maximum allowable amount must be rebilled as an adjustment. If your charges are less than the maximum allowable amount, MAA will pay your claim as billed.

- **The claim was paid, but you made an error** in procedure codes, diagnoses, or anything else that may affect payment.

- **The claim was denied, and you think the denial is not correct or valid.** Identify your reasons and resubmit as an adjustment.

- **The claim contained multiple surgical procedure codes, and one of the surgical procedures was denied or paid incorrectly.**

- **The claim was overpaid.** If you discover an overpayment, submit an adjustment. MAA will adjust your claim accordingly.

Helpful Hints

Provider Number

The Medical Assistance seven-digit billing provider number must appear in the correct field, or the claim will not appear on your remittance advice.

Indicating Units

The units/quantity billed must be indicated. **If claims are submitted without units/quantity, they will be denied.**

- For anesthesia claims, indicate actual time units in whole numbers.
- For pharmacy claims:

  - ✓ Quantities with fractions must be converted to the nearest whole number;
  - ✓ Fractions equal to, or greater than, ½ must be round to the next higher number;
  - ✓ Fractions below ½ must be rounded down to the next lowest whole number.
  - ✓ Do not round the number to the next whole number until after you have multiplied the units.

Type of Service Codes

Type of service codes must be one-character numeric. Refer to your individual program billing instructions for valid codes.

Type of Service	Claim Type/Form
3	Practitioner HCFA-1500
4	Dental/**525-108 (1-88)**
9	Medical vendor/supply HCFA-1500
Z	Practitioner Ambulatory Surgery HCFA-1500
R	Medical Vendor HCFA-1500 (Rental)

Place of Service Codes

You **must** indicate the appropriate place of service for all detail lines. For more information about this, refer to MAA's appropriate program billing instructions. Examples are:

Place of Service Codes	Description
1	Inpatient Hospital
2	Outpatient Short Stay Hospital
3	Office or Ambulatory Surgical Center
4	Client's Residence
5	Emergency Room
6	Congregate Care
7	Nursing Facility (formerly ICF)
8	Nursing Facility (formerly SNF)
9	Other

Patient Identification Code (PIC)

- This field must begin with the patient's first and middle initials, followed by the six-digit birthdate and the first five letters of the last name.

- As always, the PIC should appear as shown on the client's Medical Assistance IDentification (MAID) card.

- The next one-character alpha field is for the tiebreaker as indicated on the client's MAID card.

- If there is no middle name, enter a hyphen. If the last name has less than five letters, key the last name and space fill to create the five-character field. Space fill only if the last name is less than five characters.

- If the last name has an apostrophe (example: O'SHEA), the PIC should appear as O'SHE. If it has a hyphen (example RUS-KINGERY), the PIC should appear as RUS-K.

- **DO NOT** use spaces in the PIC code to separate the fields (e.g., first/middle initial from the birthdate or birthdate from the last name or the last name from the tiebreaker).

- The PIC code **must** contain all the above data to be accepted.

  NOTE: If the PIC code is invalid, the entire claim will be denied.

Diagnosis Code **(exception – dental; no diagnosis fields)**

- Make sure that you use a valid and current ICD-9-CM diagnosis code.
- This field has five characters. Space fill if less than five characters.
- If the diagnosis is less than five characters, DO NOT fill with a zero. Using an extra zero will change the description of the diagnosis or make the diagnosis invalid.
- Only use a zero as the fifth digit when it is actually part of the ICD-9-CM code for the diagnosis.
- DO NOT include a decimal point in this field.

NOTE: If the diagnosis is invalid or missing, the claim will be denied.

Dental Claims

- Tooth numbers must be entered as two numeric digits (e.g., 01, 02, 05, 32).
- Tooth surfaces must be one alpha character (e.g., A, B, C).
- Incorrect information will cause a delay in processing your claims.

DATA CONTROL CHARACTERS

FIELD NUMBER	FIELD	LENGTH FROM-THRU		PICTURE	FIELD DESCRIPTION/COMMENTS
1	RECORD SEQUENCE NUMBER	1	3	9(3)	REQUIRED FIELD. USED TO IDENTIFY WHICH LOGICAL RECORD ON THE FILE, 001-999 BETWEEN TRAILER HEADER/ENDERS.
2	RECORD SEGMENT NUMBER	4	5	9(2)	REQUIRED FIELD. **01** FOR THE FIRST 72 CHARACTERS, **02** FOR THE SECOND 72 CHARACTERS. IDENTIFIES WHETHER THIS IS THE FIRST OR SECOND 72 CHARACTER RECORD.
3	LENGTH OF DATA PORTION	6	7	9(2)	REQUIRED FIELD. MUST BE 72.
4	LAST SEGMENT INDICATOR	8	8	9(1)	REQUIRED FIELD. **0** FOR THE FIRST 72 CHARACTERS, **1** FOR THE LAST 72 CHARACTERS.

SPECIAL NOTES:

For electronic billing, the logical record is split into two physical 72-character records. The electronic billing record is 80 characters in length. The first 8 characters are used for data control and the remaining characters are the first (or second) part of the split electronic billing record. Insert four new fields at the beginning of the record definitions and field description for electronic billing, as follows, to accommodate the first 8 characters. (see Sample file).

FIELD NUMBER	FIELD	LENGTH FROM	LENGTH THRU	PICTURE	FIELD DESCRIPTION/COMMENTS
1	RECORD ID	1	10	X(10)	REQUIRED FIELD. MUST BE **TRANHEADER**. IDENTIFIES RECORD TYPE.
2	RECORD LENGTH	11	14	9(4)	MUST BE **0144**. THE LENGTH OF ORIGINAL EMC FILE.
3	BLOCK SIZE	15	18	9(4)	**MUST BE 0400.** THE BLOCK SIZED USED FOR TRANSMISSION.
4	RECORD FORMAT	19	19	9(1)	MUST BE **2** FOR FIXED. THE FORMAT, VARIABLE OR FIXED OF ORIGINAL EMC FILE.
5	FILLER	20	20	X(1)	MUST BE BLANKS.
6	SUBMITTER ID	21	27	9(7)	REQUIRED FIELD. MUST BE A VALID NUMBER ON FILE WITH DPS. 7-CHARACTER NUMBER ASSIGNED BY DPS TO EACH QUALIFIED SUBMITTER.
7	FILLER	28	28	X(1)	MUST BE BLANKS.
8	TRANSMISSION DATE	29	33	9(5)	REQUIRED FIELD. JULIAN DATE FORMAT YYDDD. MUST BE A VALID DATE. THE CREATION DATE OR TRANSMISSION DATE.
9	FILLER	34	34	X(1)	MUST BE BLANK.
10	SEQUENCE NUMBER	35	37	9(3)	REQUIRED FIELD. MUST BE 001, 002, 003,…999. USED TO IDENTIFY WHICH TRANSMITTER HEADER THIS IS, WITHIN EACH TRANSMISSION DATE.
11	FILLER	38	80	X(43)	MUST BE BLANK.

SUBMITTER HEADER RECORD

The submitter header record is the first record of each file. Its purpose is to identify the submission and the submitter.

FIELD NUMBER	FIELD	LENGTH FROM-THRU		PICTURE	FIELD DESCRIPTION/COMMENTS
1	RECORD ID	1	9	X(2)	VALID VALUE IS **A1** REQUIRED FIELD.
2	SUBMITTER ID	3	11	X(9)	7-CHARACTER NUMBER ASSIGNED BY DPS. REQUIRED FIELD.
3	CLAIM TYPE	12	12	X(1)	IDENTIFIES THE TYPE OF CLAIM CONTAINED IN THE FILE. REQUIRED FIELD. VALID VALUE: D = DRUG J = PHYSICIAN K = DENTAL P = MEDICAL VENDOR
4	PROCESS DATE	13	18	9(6)	THE CREATION DATE OF THE FILE. REQUIRED FIELD MUST BE A VALID DATE (MMDDYY).
5	FILLER	19	72	X(54)	MUST BE BLANKS.

MUST FOLLOW THE TRANHEADER RECORD

NON INSTITUTIONAL CLAIM HEADER RECORD
Must follow A1 record or precede DM record

FIELD NUMBER	FIELD	LENGTH FROM-THRU		PICTURE	FIELD DESCRIPTION/COMMENTS
1	RECORD ID	1	2	X(2)	IDENTIFIES TYPE OF EMC RECORD REQUIRED FIELD. MUST BE **HM**
2	SUBMITTER ID	3	11	X(9)	7-CHARACTER NUMBER ASSIGNED BY DPS. REQUIRED FIELD. MUST BE IDENTICAL TO SUBMITTER HEADER RECORD.
3	CLAIM TYPE	12	12	X(1)	IDENTIFIES THE TYPE OF CLAIM CONTAINED IN THE FILE. REQUIRED FIELD. MUST BE IDENTICAL TO SUBMITTER HEADER RECORD.
4	SEQUENCE NUMBER	13	14	9(2)	IDENTIFIES THE CLAIM HEADER. REQUIRED FIELD. MUST BE **00**
5	BILLING PROVIDER NUMBER	15	23	X(9)	7 CHARACTER MEDICAID PROVIDER NUMBER FOR THE BILLING PROVIDER. REQUIRED FIELD. MUST BE A VALID NUMBER ON FILE WITH DPS.
6	DETAIL RECORD COUNT	24	25	9(2)	REQUIRED FIELD. VALID VALUES ARE 01, 02, 03,…21. THE MAXIMUM NUMBER OF DETAILS IS 21. INDICATES THE NUMBER OF DETAIL RECORDS FOLLOWING THIS RECORD.
7	CLIENT ID	26	39	X(14)	CLIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER (PATIENT IDENTIFICATION CODE – PIC). REQUIRED FIELD. IIMMDDYYLLLLLT. IF NO MIDDLE INITIAL, ENTER A DASH (-). IF LAST NAME IS LESS THAN 5 CHARACTERS, ENTER BLANKS.
8	CLIENT SEX	40	40	X(1)	SEX OF MEDICAL ASSISTANCE CLIENT. OPTIONAL FIELD. BLANK IF NOT AVAILABLE. VALID VALUES ARE M OR F.
9	MEDICAL RECORD NUMBER	41	49	X(9)	UP TO 9 – CHARACTERS MAY BE ENTERED. INFORMATION WILL BE PRINTED ON THE RA IN THE COLUMN HEADED **MEDICAL RECORD NUMBER.** OPTIONAL FIELD.

NON INSTITUTIONAL CLAIM HEADER RECORD

FIELD NUMBER	FIELD	LENGTH FROM-THRU		PICTURE	FIELD DESCRIPTION/COMMENTS
10	FILLER	50	53	X(4)	MUST BE BLANKS.
11	TOTAL BILLED	54	60	9(7)	TOTAL DOLLAR AMOUNT BILLED FOR ALL SERVICES ON ONE CLAIM. REQUIRED FIELD. TWO DECIMAL PLACES ARE ASSUMED (XXXXX.XX). MUST EQUAL THE SUM OF DETAIL BILLED AMOUNTS FOR THE CLAIM.
12	PATIENT LIABILITY	61	67	9(7)	AMOUNT RECEIVED FROM THE CLIENT IN PAYMENT OF THE CLAIM.
13	OTHER INSURANCE INDICATOR	68	68	X(1)	REQUIRED FIELD. IF CODED N, FIELD 14 MUST BE BLANK. IF CODE IS Y, FIELD 14 MAY NOT BE BLANK. VALID CODES ARE N= NO INSURANCE COVERAGE (OTHER THAN MEDICARE OR MEDICAID,) OR Y=YES THIRD PARTY LIABILITY WHICH MAY PAY IN WHOLE OR PART FOR THE SERVICES BILLED.
14	OTHER INSURANCE PAYMENT AMOUNT	69	75	9(7)	REQUIRED FIELD. TWO DECIMAL PLACES ARE ASSUMED – XXXXX.XX. IF NO INSURANCE PAYMENT, FIELD VALUE IS ZERO. AMOUNT OF PAYMENT MADE BY ANY THIRD PARTY TOWARD SATISFACTION OF THE CLAIM. RECORD SPLITS AFTER 72ND POSITION – REPEAT DATA CONTROL CHARACTERS FOR THE 2ND PART OF HM RECORD.
15	NET BILLED AMOUNT	76	82	9(7)	REQUIRED FIELD. TWO DECIMAL PLACES ARE ASSUMED – XXXXX.XX. TOTAL BILLED AMOUNT MINUS OTHER PAYMENTS BY ANY OTHER SOURCE.
16	REFERAL INDICATOR	83	83	(1)	**F** = REFERRED FROM, OR BLANK IF FIELD 17 IS BLANK. FIELD 16 AND 17 MUST BOTH BE BLANK OR BOTH MUST CONTAIN DATA AS APPROPRIATE. SERVICES BEING BILLED ARE THE RESULT OF A REFERRAL FROM ANOTHER PROVIDER.

NON INSTITUTIONAL CLAIM HEADER RECORD

FIELD NUMBER	FIELD	LENGTH FROM-THRU		PICTURE	FIELD DESCRIPTION/COMMENTS
17	REFERRING PROVIDER NUMBER	84	92	X(9)	REQUIRED FIELD IF FIELD 16'S VALUE IS **F**. MUST BE A VALID MEDICAL ASSISTANCE PROVIDER NUMBER ON FILE WITH DPS. SERVICES WERE REFERRED FROM OR ORDERED BY ANOTHER PROVIDER.
18	INDICATOR/ITA	93	93	X(1)	OPTIONAL FIELD. BLANK IF NOT APPLICABLE ALSO USED FOR THE FOLLOWING INDICATORS: B – BABY USING PARENT'S PIC G – TPR BYPASS FOR MNCP I – INVOLUNTARY TREATMENT ACT CLAIM Q – TAKE HOME/SCHOOL/CAMP/WKND/MEDS S – SUICIDAL RISK
19	DIAGNOSIS CODE 1	94	98	X(5)	REQUIRED FIELD. MUST BE ICD-9-CM CODE. DECIMAL IS ASSUMED. FIRST DIAGNOSIS CODE LISTED BY THE PROVIDER.
20	DIAGNOSIS CODE 2	99	103	X(5)	OPTIONAL FIELD. BLANK IF NOT APPLICABLE. SECOND DIAGNOSIS CODE LISTED BY THE PROVIDER.
21	FILLER	104	144	X(41)	MUST BE BLANK

*NOTE: ICD-9-CM Codes may be 3, 4 or 5 characters in length. Be sure that fields 19 & 20 report EXACT codes. DO NOT zero fill this field.

EXAMPLES: V65 = |V|6|5| | | 789 = 7|8|9| | |
V65.0 = V|6|5|0| | V25.40 = V|2|5|4|0|

NON-INSTITUTIONAL CLAIM DETAIL RECORD

FIELD NUMBER	FIELD	LENGTH FROM	LENGTH THRU	PICTURE	FIELD DESCRIPTION/COMMENTS
1	RECORD ID	1	2	X(2)	REQUIRED FIELD. MUST BE **DM**. IDENTIFIES TYPE OF RECORD.
2	SUBMITTER ID	3	11	X(9)	REQUIRED FIELD. MUST BE IDENTIAL TO SUBMITTER HEADER RECORD. 7-CHARACTER NUMBER ASSIGNED BY DPS TO EACH SUBMITTER.
3	CLAIM TYPE	12	12	X(1)	REQUIRED FIELD. MUST BE IDENTICAL TO SUBMITTER HEADER RECORD FIELD 2. IDENTIFIES THE TYPE OF CLAIM CONTAINED IN THE RECORD.
4	SEQUENCE NUMBER	13	14	9(2)	REQUIRED FIELD. MAXIMUM NUMBER OF DETAILS IS 21. SEQUENTIALLY IDENTIFIES NUMBER OF DETAILS ASSOCIATED WITH EACH CLAIM. (EXAMPLE: IF A CLAIM HAS SIX DIFFERENT SERVICES, THE HEADER RECORD INDICATES SIX **DM** RECORDS FOLLOWING THE CLAIM HEADER. THIS FIELD INDICATES WHICH **DM** RECORD THIS IS. THE FIRST SEQUENCE NUMBER IS **01**, THE SECOND **02**, AND SO ON UP TO A MAXIMUM OF 21.
5	BILLED AMOUNT	15	21	9(7)	REQUIRED FIELD. TWO DECIMAL PLACES ARE ASSUMED – XXXXX.XX. THE AMOUNT BILLED FOR THE DETAIL PROCEDURE.
6	TYPE OF SERVICES	22	22	X(1)	REQUIRED FIELD. MUST BE A VALID SERVICE TYPE. VALID VALUES ARE LISTED ON PAGE 28.
7	DETAIL DATE OF SERVICE	23	28	9(6)	REQUIRED FIELD. MUST BE MMDDYY. THE DATE OF SERVICE OF THE DETAIL.
8	DETAIL REFERENCE NUMBER	29	34	X(6)	OPTIONAL FIELD. BLANK IF NOT USED.
9	PLACE OF SERVICE	35	35	9(1)	REQUIRED FIELD. MUST BE A VALID PLACE OF SERVICE. VALID NUMBERS ARE LISTED ON PAGE 29.

Must follow HM record or precede DM record.

NON-INSTITUTIONAL CLAIM DETAIL RECORD (cont.)

FIELD NUMBER	FIELD	LENGTH FROM	LENGTH THRU	PICTURE	FIELD DESCRIPTION/COMMENTS
10	PERFORMING PROVIDER NUMBER	36	44	X(9)	REQUIRED FIELD. IF NUMBER IS DIFFERENT FROM BILLING PROVIDER NUMBER. MUST BE A VALID BILLING PROVIDER NUMBER. MUST BE A VALID PERFORMING PROVIDER NUMBER ON FILE WITH DPS. MAY SUBMIT ONLY ONE PERFORMING PROVIDER PER CLAIM. 7-CHARACTER MEDICAL ASSISTANCE PROVIDER NUMBER OF THE PRACTITIONER WHO PERFORMED THE DETAIL SERVICE.
11	PROCEDURE CODE	45	49	X(5)	REQUIRED FIELD. PROCEDURE CODE FOR THE SERVICES PERFORMED.
12	MODIFIER/TOOTH NUMBER	50	51	X(2)	OPTIONAL FIELD. BLANK IF NOT APPLICABLE. MUST CONTAIN VALID PROCEDURE CODE MODIFIERS. TOOTH NUMBER FOR DENTAL CLAIM TYPE. VALID TOOTH NUMBERS ARE 01 TO 32, A THROUGH T, SN, UA, LA, UL, OR, LR, LL.
13	QUANTITY	52	55	9(4)	REQUIRED FIELD. ONE DECIMAL PLACE IS ASSUMED XXX.XX. RIGHT JUSTIFY AND FILL WITH ZEROS. EXAMPLE: TO BILL FOR ONE UNIT FIELD VALUE WILL BE 0010.
14	DIAGNOSIS CODE/ TOOTH SURFACE	56	60	9(5)	REQUIRED FIELD FOR DENTAL CLAIMS. FOR ALL OTHER CLAIM TYPES FIELD MAY BE BLANK. IF BLANK, THE HEADER PRIMARY DIAGNOSIS WILL APPLY. DECIMAL IS ASSUMED. DETAIL DIAGNOSIS CODE FOR PHYSICIAN CLAIM TYPES. TOOTH SURFACE ON DENTAL CLAIMS.
15	PRIOR AUTHORIZATION NUMBER	61	69	X(9)	OPTIONAL FIELD. ZERO IF NOT APPLICABLE. MUST BE A VALID PRIOR AUTHORIZATION NUMBER. MAY SUBMIT ONLY ONE AUTHORIZATION NUMBER PER CLAIM. AUTHORIZATION NUMBER IS OBTAINED FROM MEDICAL ASSISTANCE INDICATING THAT THE SERVICE HAS BEEN APPROVED.

NON-INSTITUTIONAL CLAIM DETAIL RECORD (cont.)

FIELD NUMBER	FIELD	LENGTH FROM	LENGTH THRU	PICTURE	FIELD DESCRIPTION/COMMENTS
16	FILLER	70	75	X(6)	MUST BE BLANKS. RECORD SPLITS AFTER 72ND POSITION-REPEAT DATA CONTROL CHARACTERS FOR THE 2ND HALF OF DM RECORD.
17	PRIOR AUTHORIZATION DATE	76	81	9(6)	MUST BE ZEROS. TO BE DEVELOPED.
18	FILLER	82	87	X(6)	MUST BE BLANK.
19	DETAIL NARRATIVE	88	127	X(40)	OPTIONAL FIELD. BLANK IF NOT APPLICABLE. NARRATIVE COMMENT CONCERNING THIS DETAIL. MAY CONTAIN REBILLING INFORMATION. SEE SECTION ON POSSIBLE NARRATIVE COMMENTS.
20	FILLER	128	144	X(17)	MUST BE BLANKS.

DRUG CLAIM HEADER RECORD

FIELD NUMBER	FIELD	LENGTH FROM-THRU		PICTURE	FIELD DESCRIPTION/COMMENTS
1	RECORD ID	1	2	X(2)	REQUIRED FIELD. MUST BE **HD**. INDICATES RECORD TYPE.
2	SUBMITTER ID	3	11	X(9)	MUST BE IDENTICAL TO SUBMITTER HEADER RECORD, 7-CHARACTER NUMBER ASSIGNED BY DPS TO EACH SUBMITTER.
3	CLAIM TYPE	12	12	X(1)	REQUIRED FIELD. MUST BE "D."
4	SEQUENCE NUMBER	13	14	9(2)	REQUIRED FIELD. MUST BE 00. IDENTIFIES CLAIM HEADER.
5	BILLING PROVIDER NUMBER/NABP	15	23	X(9)	REQUIRED FIELD. MUST HAVE VALID NUMBER ON FILE WITH DPS. THE 7-CHARACTER NABP NUMBER OF THE PHARMACY BILLING THE PRESCRIPTION.
6	CLIENT ID	24	37	X(14)	REQUIRED FIELD. FORMAT: IIMMDDYYLLLLLT. FIRST AND MIDDLE INITIALS, BIRTHDATE, FIRST FIVE CHARACTERS OF THE LAST NAME, TIEBREAKER. THE CLIENTS PATIENT IDENTIFICATION CODE (PIC) FROM HIS/HER MEDICAL ASSISTANCE IDENTIFICATION CARD.
7	CLIENT SEX	38	38	X(1)	OPTIONAL FIELD. BLANK IF NOT AVAILABLE. VALID VALUES ARE M OR F.
8	PRESCRIPTION NUMBER	39	45	9(7)	REQUIRED FIELD. ENTER UP TO 7-CHARACTERS. THIS INFORMATION WILL BE PRINTED ON THE REMITTANCE ADVICE IN THE FIELD HEADED **MEDICAL RECORD NUMBER**

DRUG CLAIM HEADER RECORD (cont.)

FIELD NUMBER	FIELD	LENGTH FROM-THRU		PICTURE	FIELD DESCRIPTION/COMMENTS
9	INDICATOR/ ITA FIELD	46	46	X (1)	OPTION FIELD. ALSO USED FOR THE FOLLOWING INDICATORS: B – BABY USING PARENTS PIC G – TPR BYPASS FOR MNCP I – ITA CLAIM Q – TAKE HOME/SCHOOL/CAMP/WKND/MD S – SUICIDAL RISK X – MHCP PRESCRIPTION 1 – PREVIOUS IN HOUSE UNIT DOSE 2 – COMPOUND DRUG 3 – IN HOUSE UNIT DOSE
10	FILLER	47	51	X(5)	MUST BE BLANK.
11	TOTAL BILLED	52	58	9(7)	REQUIRED FIELD. TWO DECIMAL PLACES ARE ASSUMED – XXXXX.XX. MUST EQUAL THE SUM OF DETAIL BILLED AMOUNT FOR THE CLAIM. TOTAL DOLLAR AMOUNT OF THE CLAIM.
12	PATIENT LIABILITY	59	65	9(7)	REQUIRED FIELD IF APPLICABLE. TWO DECIMAL PLACES ARE ASSUMED – XXXXX.XX. RIGHT JUSTIFY AND FILL WITH ZEROS. MUST BE ZEROS IF NOT APPLICABLE.
13	OTHER INSURANCE INDICATOR	66	66	X(1)	REQUIRED FIELD. IF CODED N. FIELD 14 MUST BE ZERO. IF CODED Y, FIELD 14 MAY OR MAY NOT BE ZERO. N = NO INSURANCE COVERAGE IS PRESENT OR KNOWN. Y – OTHER COVERAGE IS INVOLVED. INDICATES PATIENT WITH HEALTH, ACCIDENT OR OTHER INSURANCE, GOVERNMENT SYSTEM COVERAGE (OTHER THAN MEDICARE OR MEDICAL ASSISTANCE), OR THIRD PARTY LIABILITY WHICH MAY PAY IN WHOLE OR PART FOR THE SERVICES BILLED.

DRUG CLAIM HEADER RECORD (cont.)

FIELD NUMBER	FIELD	LENGTH FROM-THRU		PICTURE	FIELD DESCRIPTION/COMMENTS
14	OTHER INSURANCE PAYMENT AMOUNT	67	73	9(7)	REQUIRED FIELD IF APPLICABLE. IF FIELD 13 IS N, MUST BE ZEROS. TWO DECIMAL PLACES ARE ASSUMED – XXXXX.XX. INSURANCE PAYMENT AMOUNT. RECORD SPLITS AFTER 72ND POSITION – REPEAT DATA CONTROL CHARACTERS FOR THE 2ND INSURANCE.
15	NET BILLED AMOUNT	74	80	(X)7	TWO DECIMAL PLACES ARE ASSUMED- XXXXX.XX. TOTAL BILLED AMOUNT MINUS OTHER PAYMENTS BY THE CLIENT OR INSURANCE.
16	DIAGNOSIS CODE	81	85	Z(5)	OPTIONAL. DECIMAL PLACES ARE ASSUMED – XXXXX.XX. TOTAL BILLED AMOUNT MINUS OTHER PAYMENTS BY THE CLIENT OR INSURANCE.
17	FILLER	86	144	(X)59	MUST BE BLANK.

DRUG CLAIM DETAIL RECORD

FIELD NUMBER	FIELD	LENGTH FROM-THRU		PICTURE	FIELD DESCRIPTION/COMMENTS
1	RECORD ID	1	2	X(2)	REQUIRED FIELD. MUST BE **DD**. IDENTIFIES RECORD TYPE.
2	SUBMITTER ID	3	11	X(9)	MUST BE IDENTICAL TO SUBMITTER HEADER RECORD. 7 – CHARACTER IDENTIFYING NUMBER ASSIGNED BY DPS TO EACH SUBMITTER.
3	CLAIM TYPE	12	12	X(1)	REQUIRED FIELD. MUST BE D. IDENTIFIES TYPE OF CLAIM IN THE FILE.
4	SEQUENCE NUMBER	13	14	X(2)	REQUIRED FIELD. MUST BE 01. USED TO IDENTIFY DRUG DETAIL.
5	BILLED AMOUNT	15	21	X(7)	REQUIRED FIELD. TWO DECIMAL PLACES ARE ASSUMED – XXXXX.XX. THE BILLED AMOUNT FOR THE DETAIL.
6	FILL DATE	22	27	9(6)	REQUIRED FIELD. MMDDYY. THE DATE THE PRESCRIPTION WAS FILLED.
7	DRUG CODE	28	38	9(11)	REQUIRED FIELD. MUST CONTAIN ALL 11 DIGITS OF THE NATIONAL DRUG CODE (NDC) OF THE DRUG SUPPLIED, INCLUDING ANY LEAD ZEROS. EXAMPLE: 74-32-15 = 00074003215.
8	REFILL INDICATOR	39	39	X(61	ENTER **Y** IF REFILL, IF NOT A REFILL LEAVE BLANK.
9	DRUG QUANTITY	40	43	9(4)	REQUIRED FIELD. NO DECIMAL PLACE IS ASSUMED – XXXX. NUMBER OF UNITS OF THE DRUG SUPPLIED.
10	REGIMEN/ DOSAGE ESTIMATED DAYS	44	46	9(3)	REQUIRED FIELD. NO DECIMAL PLACE IS ASSUMED – XXX. NUMBER OF UNITS OF THE DRUG SUPPLIED.

1 detail record only is required for each prescription must follow HD record

DRUG CLAIM DETAIL RECORD (cont.)

FIELD NUMBER	FIELD	LENGTH FROM-THRU		PICTURE	FIELD DESCRIPTION/COMMENTS
11	NURSING HOME INDICATOR	47	47	X(1)	REQUIRED FIELD. FIELD VALUES: Y = YES N = NO INDICATES WHETHER PRESCRIPTION WAS WRITTEN FOR A PATIENT RESIDING IN A NURSING HOME.
12	CERTIFICATE INDICATOR	48	48	X(1)	NOT USED. MUST BE BLANK. INDICATES WHETHER PRESCRIBING PROVIDER PERMITS SUBSTITUTION OF GENERIC EQUIVALENT DRUG.
13	PRESCRIBING PROVIDER NUMBER	49	57	X(9)	REQUIRED FIELD. MUST BE A VALID MEDICAID PROVIDER NUMBER ON FILE WITH DPS. 7 – CHARACTER MEDICAID PROVIDER NUMBER OF THE PHYSICIAN WHO PRESCRIBED THE DRUG. IF PRESCRIBING PROVIDER HAS NO MEDICAL ASSISTANCE PROVIDER NUMBER, ENTER THE LAST NAME.
14	FILLER	58	61	X(4)	MUST BE BLANKS.
15	DETAIL REFERENCE NUMBER	62	67	X(6)	NOT USED. MUST BE BLANKS.
16	PRIOR AUTHORIZATION NUMBER	68	76	X(9)	REQUIRED IF APPLICABLE. BLANK IF NOT APPLICABLE. MUST BE VALID AUTHORIZATION NUMBER ON FILE WITH DPS. 9 – CHARACTER NUMBER WHICH INDICATES THAT THE SERVICE HAS BEEN REVIEWED BY MEDICAL ASSISTANCE.
17	FILLER	77	82	X(6)	MUST BE BLANKS.
18	PRIOR AUTHORIZATION DATE	83	88	9(6)	MUST BE ZEROS. NOT USED.

DRUG CLAIM DETAIL RECORD (cont.)

FIELD NUMBER	FIELD	LENGTH FROM-THRU		PICTURE	FIELD DESCRIPTION/COMMENTS
19	FILLER	89	92	X(4)	MUST BE BLANKS.
20	DETAIL NARRATIVE COMENT	93	132	X(40)	NOT USED FOR DRUG CLAIMS.
21	DUR CODES	133	138	X(6)	CONFLICT, INTERVENTION AND OUTCOME CODES.
22	FILLER	139	144	(X)6	MUST BE BLANKS.

SUBMITTER TRAILER RECORD

The submitter trailer is the next to the last record. It contains control totals that will be used to balance the file.

FIELD NUMBER	FIELD	LENGTH FROM-THRU		PICTURE	FIELD DESCRIPTION/COMMENTS
1	RECORD ID	1	2	X(2)	REQUIRED FIELD. MUST BE **Z9**. IDENTIFIES RECORD TYPE.
2	SUBMITTER ID	3	11	X(9)	REQURED FIELD. MUST BE SAME AS TRANHEADER CONTROL RECORD. 7-CHARARACTER NUMBER ASSIGNED BY DPS TO EACH SUBMITTER.
3	PROCESS DATE	12	17	9(6)	REQUIRED FIELD, MUST BE IDENTICAL TO THE SUBMITTER HEADER RECORD. FILE CREATION DATE. (MMDDYY)
4	CLAIM COUNT	18	24	9(7)	REQUIRED FIELD. MUST EQUAL THE NUMBER OF CLAIM HEADER RECORDS WITHIN THE BATCH FILE.
5	RECORD COUNT	25	31	9(7)	REQUIRED FIELD. MUST EQUAL THE NUMBER OF SUBMITTER HEADER & TRAILER, AND CLAIM HEADER & DETAIL RECORDS IN THE FILE.
6	TOTAL BILLED AMOUNT	32	40	9(9)	REQURED FIELD, TWO DECIMAL PLACES ARE ASSUMED – XXXXXXX.XX. MUST EQUAL THE SUM OF ALL TOTAL BILLED FIELDS ON ALL CLAIM HEADERS. **NOTE:** THIS FIELD REQUIRES SUM OF **TOTAL BILLED** FIELDS, **NOT** NET BILLED FIELDS**.**
7	FILLER	41	72	X(32)	MUST BE BLANK.

Website Update Only – Correction to Field 4 in the Field Description.

FIELD NUMBER	FIELD	LENGTH FROM-THRU		PICTURE	FIELD DESCRIPTION/COMMENTS
1	RECORD ID	1	9	X(9)	REQUIRED FIELD. MUST BE **TRANENDER**. IDENTIFIES TYPE OF RECORD.
2	FILLER	10	12	X(3)	MUST BE BLANK.
3	RECORD COUNT	13	15	9(3)	REQUIRED FIELD. THE NUMBER OF LOGICAL RECORDS WITHIN THIS TRANSMISSION HEADER/ENDER BATCH.
4	FILLER	16	20	X(5)	MUST BE BLANK.
5	SUBMITTER ID	21	27	9(7)	REQUIRED FIELD. MUST BE VALID NUMBER ON FILE WITH DPS. MUST BE SAME NUMBER AS TRANHEADER SUBMITTER ID NUMBER. 7-CHARACTER NUMBER ASSIGNED BY DPS TO EACH SUBMITTER.
6	FILLER	28	28	X(1)	MUST BE BLANK.
7	TRANSMISSION DATE	29	33	9(5)	REQUIRED FIELD. JULIAN DATE FORMAT YYDDD. MUST BE A VALID DATE AND MATCH DATE IN TRANHEADER. THE CREATION OR TRANSMISSION DATE.
8	FILLER	34	34	X(1)	MUST BE BLANK.
9	SEQUENCE NUMBER	35	37	9(3)	REQUIRED FIELD. USED TO IDENTIFY WHICH TRANSMITTER ENDER, WITHIN TRANSMISSION.
10	FILLER	38	80	X(43)	MUST BE BLANK.